Testimony of Allison Bayer, Acting CEO, Cambridge Health Alliance (CHA)
June 29, 2011

Thank you for the opportunity to testify as part of the panel discussion on the health resources planning needs for the 21st century. This topic is particularly important at this time, as Massachusetts continues planning for health delivery system and payment reform to achieve the goals of better health outcomes, a greater focus on wellness, and more cost-effective care. I would like to highlight five key areas for consideration.

First, change in the way in which care is organized is core to advancing a more integrated health care delivery system across the medical and mental health continuum, including ambulatory care, acute care, and community-based care. This requires new care models, including the primary-care based Patient-Centered Medical Home (PCMH) and integrated care networks working as part of a care team to promote health, manage chronic disease, and make health care more seamless and effective for the patient as well as for the care providers. CHA is innovating in these directions, and has made progress with two of our primary care sites receiving NCQA level three PCMH recognition and three more in process, and has initiated new integrated care global payment initiatives for a subset of our Medicaid managed care and Commonwealth Care members and for frail elders dually eligible for Medicare and Medicaid. Planning for skilled, effective health resources in a new model of care delivery needs to take into account the focus on teamwork and care management as core elements of the model.

Second, as we move to a new model of integrated care, payment disparities as highlighted in the recent Health Care Cost Trends reports, profoundly affect the health resources capacity across the state and patient care access to critical services. This is especially true in behavioral health and oral health services, which has led to gaps in services availability due to chronic under-payments across all payers. The refocus on care with the patient at the center is foundational to the goals of payment reform, and the structure for financing the delivery of care. The movement to Accountable Care Organizations requires new investments in infrastructure, start-up requirements, and many providers, especially those who serve a disproportionate share of low-income populations, are not positioned to make these investments without new dedicated funding support. Payment reforms are also needed to address documented payment disparities that cannot be the basis for the new global payment and accountable care models of the future.

Third, workforce transformation requires robust training and support to the workforce in the new roles and responsibilities of patient-centered, integrated care. At community-based health systems like CHA, approximately 70% of service line expenditures are for staffing. And in our case, 69% of our employees are represented by organized labor, underscoring our partnership going forward in redefining, training and incenting the workforce for new responsibilities as team members, integral to health outcomes and patient satisfaction in care provision and self management.

Planning and engaging in care team development, and new roles and responsibilities that permit health care professionals to work to the top of their license while empowering traditional support staff to work as patient navigators coordinating patient care toward patient self-activation is key to health resource planning. CHA has early experience in piloting and deploying innovations with community health workers and volunteer health advisors as part of the care team doing health outreach in the community. To highlight one example of this work, a published study conducted by one of our clinicians, Dr. Karen Lasser, revealed that same-language patient navigation doubled the completion rate of colorectal cancer screening, and was particularly beneficial for patients whose primary language was other than English. A patient care vignette shows the difference that these approaches can make not only in improving health but also preventing more costly care requirements down the road: A 52 year old Spanish-speaking man with a family history of colon cancer had delayed the colonoscopy due to fear and a lack of someone to accompany him home after the procedure. Our Spanish-speaking patient navigator phoned him directly, then met with him and showed him pictures of the procedure and took him to the GI suite to meet the RNs who worked there. The patient navigator also found someone who could accompany the patient

1493 Cambridge Street • Cambridge, MA 02139

home. After working with the navigator for nearly two months, the patient completed the colonoscopy, which included the removal of high-risk colon polyps.

Fourth, information technology is increasingly a core platform for managing and transforming care and as such is a core element of health resource planning, both in terms of infrastructure and workforce development. The electronic medical record is a groundbreaking platform for primary care teams to manage preventive care and chronic health conditions for their panels of patients. It is also a platform for better coordinating care across providers in the outpatient and inpatient setting. Inter-operable electronic medical records and communication protocols across providers who are not in the same health system is the next generation of this work; this is especially true in extending information sharing into community based settings and the patient's home, where the ability to impact patient health outcomes can be equally or more critical than services provided within the walls of the health care provider's venue. Finally, patient portals are a core new secure means for patients to be involved in their care, including direct communication with their care team.

A fifth and final area I would like to note today is the partnership with public health as a cornerstone to wellness. The health care delivery system on its own cannot fix all that ails us. Many of the solutions to today's health challenges such as obesity, diabetes, and environmental triggers to asthma, require collaboration that bridges the traditional divide between public health and the care delivery system. At CHA we incorporate our work with the Cambridge Public Health Department and collaboration with state and local public health departments and community organizations, to advance improved population health.

CHA's Childhood Asthma Program started in 2002, highlights many of my points today. We created a web-based asthma patient registry that contains information about the patients' condition and treatment plan, and is available not only to CHA providers, but (with patient/family permission) to public- school nurses and community-based health workers as well. To support parents in managing their children's asthma, we developed online asthma educational resources and tools such as web-based prescription refill, and provide home visits by a community health worker and a registered nurse who evaluate asthma triggers in the home. Patient outcomes are significantly improved. Since the 2001 baseline, CHA has reduced annual pediatric asthma-related admissions by 90% and emergency department visits by 65%. Estimates are a savings of about $4 for every $1 invested, but because most reimbursements are fee-for-service and most of the community outreach services are not reimbursed, reducing services utilization has benefited payers and patients, but does not align reimbursement incentives with the provider to be able to extend these kinds of innovative care programs across the continuum of services and settings that can meet the integrated health care needs of the patient.

Aligning the payment system to support developing these resources, many of which are not reimbursable in today's payment environment, will be integral to achieving the results of good health and high value care we all want. Thank you again for the opportunity to contribute to the panel discussion.